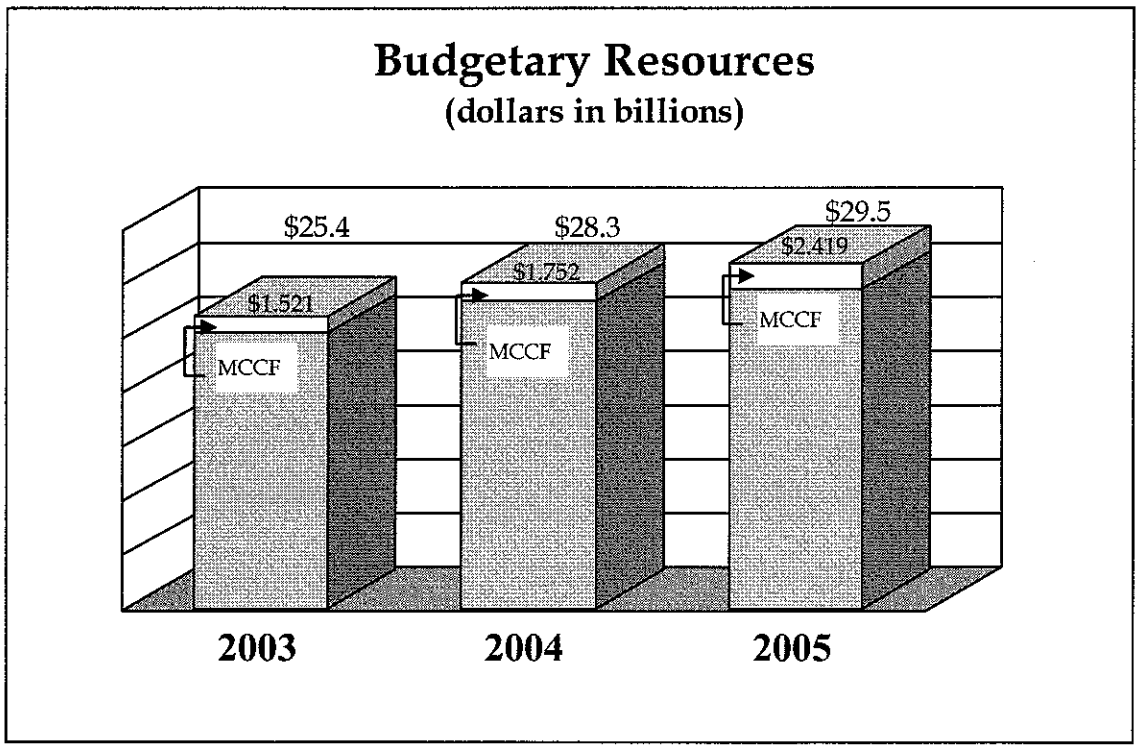
Medical Care Business Line

The Medical Care Business Line appropriation provides the resources to operate a comprehensive and integrated health care system that supports enrolled veterans; a national academic education and training program to enhance veterans' quality of care; administrative support for facilities; and capital investments necessary to ensure that the infrastructure is adequate to support the delivery of quality health care. The mission of the veterans' health care system is to serve the needs of America's veterans. Enrolled veterans receive the needed specialized and primary medical care and related social support services. To accomplish this mission, the Veterans Health Administration (VHA) is a comprehensive, integrated health care system that provides excellence in health care value; excellence in service as defined by its customers; excellence in education and research; and excellence in timely and effective contingency medical support in the event of national emergency or natural disaster. In addition, it is an organization characterized by exceptional accountability and an employer of choice.



The 2005 President's budget includes the Medical Care Business Line with budgetary resources of $29.5 billion, an increase of $1.2 billion, which represents a 4.1 percent increase over the 2004 estimate. The request reflects an offset of $1.2 billion in appropropriation for a comprehensive set of legislative, regulatory, and management proposals that will continue to concentrate VA's health care resources to meet the needs of our highest priority core veterans - those with service-connected conditions, those with lower incomes, and veterans with special health care needs. It also reflects Medical Care Collection Funds (MCCF) of $2.4 billion, an increase of $666.3 million. VHA is allowed to retain third party collections from insurance companies, first party co-payments, and related medical fees in the MCCF.

Medical Care Business Line 2005 Funding Reconciliation Summary

(dollars in thousands)

	FY 2004 1/ Estimate	FY 2005 2/ Estimate	Increase (+) Decrease (-)
Appropriation	$26,544,812	$27,051,893	+$507,081
Transfer from MCCF	1,752,404	2,418,700	+666,296
Subtotal, budget authority	28,297,216	29,470,593	+1,173,377
Reimbursements and prior year recoveries			
Sharing & other reimbursements	193,113	222,113	+29,000
Prior year recoveries	270,000	0	-270,000
Subtotal, reimbursements and recoveries	463,113	222,113	-241,000
Adjustments to obligations:			
Changes in unobligated balance	105,627	875,544	+769,917
Total, obligations	**$28,865,956**	**$30,568,250**	**+$1,702,294**

1/ 2004 reflects H.R. 2673, FY 2004 Consolidated Appropriations Bill. This includes a government-wide rescission of $160,006,000 in appropriation affecting Medical Care ($156,457,000), National Program Administration ($467,000); major construction ($1,262,000); minor construction ($1,218,000); and Grants for State Extended Care Facilities ($602,000). A rescission of $10,400,000 was also applied to the MCCF. This estimate is used on all of the following charts. H.R. 2673, section 122, rescinded $270,000,000 of unobligated balances remaining from prior year recoveries and reappropriated this funding to Medical Care as a reimbursement in 2004.

2/ Legislative proposals are reflected in administrative provisions of the budget request.

The Medical Care Business Line resources, for each account combined into the business line, are reflected in the chart below.

Medical Care Business Line 2005 Funding Reconciliation by Subaccount
(dollars in thousands)

	FY 2004 Estimate	FY 2005 Estimate	Increase (+) Decrease (-)
Medical care business line prior appropriation structure			
Medical care	$26,338,310	$26,646,474	+$308,164
Medical care research support	-414,202	-384,770	+29,432
Homeless transitional housing	-600	0	+600
National program administration (NPA-MAMOE)	86,986	87,126	+140
Construction, major (VHA portion)	212,738	400,800	+188,062
Construction, minor (VHA portion)	205,082	182,100	-22,982
Grants for State extended care facilities	101,498	105,163	+3,665
DoD VA Health Care Sharing Incentive Fund	15,000	15,000	+0
Subtotal, medical care business line appropriation	26,544,812	27,051,893	+507,081
Transfer from medical care business line collections			
Transfer from MCCF	1,702,500	2,363,710	+661,210
Long-term care co-payments	6,000	9,000	+3,000
Compensation and pension living expenses program	388	401	+13
Parking program	3,400	3,400	+0
Compensated work therapy program	40,116	42,189	+2,073
Subtotal, transfer medical care business line collections	1,752,404	2,418,700	+666,296
Subtotal, medical care business line budget authority	28,297,216	29,470,593	+1,173,377
Reimbursements and prior year recoveries			
Medical care reimbursements	193,000	222,000	+29,000
Medical care prior year recoveries	270,000	0	-270,000
NPA-MAMOE reimbursements	113	113	+0
Subtotal, reimbursements and prior year recoveries	463,113	222,113	-241,000
Adjustments to obligations:			
Changes in unobligated balance			
Medical care	-21,673	800,000	+821,673
NPA-MAMOE	1,500	0	-1,500
Construction, major (VHA portion)	12,262	74,200	+61,938
Construction, minor (VHA portion)	50,918	3,904	-47,014
Grants for State extended care facilities	55,533	-836	-56,369
Long-term care co-payments	-715	-1,363	-648
Compensation and pension living expenses program	204	161	-43
Parking program	8,253	100	-8,153
Compensated work therapy program	-655	-622	+33
Subtotal, medical care business line adj. to obligations	105,627	875,544	+769,917
Total, medical care business line obligations	**$28,865,956**	**$30,568,250**	**+$1,702,294**

Medical Care Business Line Obligations and Financing
(dollars in thousands)

	2003 Actual	2004 Estimate	2005 Estimate	Increase (+) Decrease (-)
Program:				
Provision of veterans health care:				
Acute hospital care	$6,021,758	$6,716,176	$7,314,836	+$598,660
Rehabilitative care	440,539	487,662	541,041	+53,379
Psychiatric care	1,208,396	1,250,218	1,295,953	+45,735
Nursing home care	2,398,509	2,309,588	2,016,283	-293,305
Subacute care	289,039	259,803	233,709	-26,094
Residential care	474,405	523,057	575,444	+52,387
Outpatient care	12,609,807	14,510,783	15,476,587	+965,804
Miscellaneous benefits and services	1,498,938	1,648,832	1,731,273	+82,441
CHAMPVA	332,402	433,207	530,554	+97,347
National program administration	79,058	88,599	87,239	-1,360
Construction, major projects	128,505	225,000	475,000	+250,000
Construction, minor projects	156,414	256,000	186,004	-69,996
Grants for State extended care facilities	172,849	157,031	104,327	-52,704
Total obligations	**$25,810,619**	**$28,865,956**	**$30,568,250**	**+$1,702,294**
Financing:				
Medical care business line	$23,859,734	$26,704,818	$27,051,893	+$347,075
Appropriation transfers 1/	5,250	0	0	+0
Rescissions (P.L. 108-7 and H.R. 2673) 2/	-2,538	-160,006	0	160,006
Transfer from MCCF (net of rescission) 3/	1,520,683	1,752,404	2,418,700	+666,296
Reimbursements	175,149	193,113	222,113	+29,000
Recovery prior year obligations	85,500	270,000	0	-270,000
Unobligated balance expiring	-339	0	0	+0
Unobligated balance available (SOY)	1,428,365	1,261,185	1,155,558	-105,627
Unobligated balance (EOY)	-1,261,185	-1,155,558	-280,014	+875,544
Total resources	**$25,810,619**	**$28,865,956**	**$30,568,250**	**+$1,702,294**
FTE	**183,802**	**190,310**	**192,641**	**2,331**

1/ 2003 reflects a transfer of $5,000,000 from the Medical and Prosthetic Research Business Line to the Medical Care Business Line for the Office of Research Compliance and Assurance (ORCA) and $250,000 from the Pershing Hall revolving fund to major construction.

2/ 2003 and 2004 reflect government-wide rescissions of $2,538,000 enacted in P.L. 108-7 and $160,006,000 proposed in H.R. 2673, respectively.

3/ 2003 and 2004 reflect collections from the Long-term co-payments, Compensation and Pension Living Expenses Program, Parking Program, and Compensated Work Therapy Program for comparable purposes because these collections will be consolidated into the MCCF in 2004. In 2004, a rescission of $10,400,000 was applied to the MCCF.

At the start of a new century, the transformation in the VA health care system continues. Events such as changes in health care financing, provisions of new services, new collaborative arrangements, and new technologies continue to impact the evolving marketplace. Profound changes have occurred in the health care system and even more change is expected as the Department continues to enhance quality, increase access, improve service satisfaction, and optimize patient functioning. VA's transformation has led to a truly coordinated continuum of care and a system characterized by achievement of performance outcomes to improve services to veterans. VA continues to develop its national, integrated health care delivery system. The future system will require VA components to function together and in concert with public and private health care facilities, to meet the health care needs of the enrolled population, and to minimize duplication of services. This system will promote efficiency, assure high-quality care, and provide optimal access for the veteran population.

Medical Workload Growth and Quality of Care

VA continues to experience growth in the medical system workload, which is escalating at a pace greater than available resources. The total number of users grew by 64 percent from 1996 to 2003. During this 7-year period, the percentage increase in comparatively higher income veterans (Priority 7-8) far exceeded the growth in the total patient population; the number of priority 7 and 8 patients was 12 times higher in 2003 than it was in 1996. This unprecedented growth led VA to suspend the enrollment of new Priority 8 veterans on January 17, 2003, in order to focus its resources on health care for the Department's core constituents.

VA experienced an annual growth rate of 6.2 percent in 2003 as the number of patients treated increased from 4.7 million in 2002 to 5.0 million in 2003. During 2003, VA treated over 120,000 new patients among VA's highest priority veterans, Priority 1 through 6, and 133,000 new patients among Priority 7 and 8 veterans. In 2003, some veterans were placed on a waiting list before they received care. With this request and the anticipated funding for 2004, VA plans to eliminate the current waiting list in early 2004.

VA will continue to bring balance back to its health care system priorities by remaining focused on meeting the needs of our highest priority veterans. The number of patients within this core service population that we project will come to VA for health care in 2005 will be 12 percent higher than in 2003. By highlighting our focus on our core constituency, we will continue to produce the desired change in the composition of the veteran population that uses our health care services. During 2005, 71 percent of those using VA's health care system will be veterans with service-connected conditions, those with lower incomes, and veterans with special health care needs. The comparable share in 2003 was 66 percent. In addition, we devote 88 percent of our health care resources to meet the needs of these veterans.

Due to their advancing age and multiple medical problems, our highest priority veterans require much more extensive care that requires significantly more resources, on average, than lower priority veterans. In 2004, VA estimates treating 3.5 million highest priority veterans, Priority 1-6, representing an increase over 2003 of over 275,000, or 8.4 percent. In 2005, this trend continues as VA anticipates treating 3.7 million in this core population, an increase of 3 percent, or over 118,000 new patients. As a direct result of the enrollment decision, the Department expects to treat about 195,000 (or 16 percent) fewer patients in the lower priority groups (Priorities 7-8) in 2005 as compared to the estimate for 2004.

Unique Patients

Description	2003 Actual	2004 Budget 3/ Estimate	2004 Current Estimate	2005 Estimate	Increase/ Decrease
Priorities 1-6.....	3,266,933	3,612,970	3,541,931	3,660,543	118,612
Priorities 7-8 1/.....	1,277,497	748,740	1,199,680	1,004,340	-195,340
Subtotal Veterans.....	4,544,430	4,361,710	4,741,611	4,664,883	-76,728
Non-Veterans 2/.....	417,023	474,588	472,539	487,073	14,534
Total Unique.....	4,961,453	4,836,298	5,214,150	5,151,956	-62,194

Enrollees 4/

Description	2003 Actual	2004 Budget 3/ Estimate	2004 Current Estimate	2005 Estimate	Increase/ Decrease
Priorities 1-6.....	4,887,615	4,859,305	5,296,113	5,496,178	200,065
Priorities 7-8 1/.....	2,299,028	1,007,683	2,336,303	1,246,539	-1,089,764
Total Enrollees.....	7,186,643	5,866,988	7,632,416	6,742,717	-889,699

Users as Percent of Enrollees

Description	2003 Actual	2004 Budget Estimate	2004 Current Estimate	2005 Estimate	Increase/ Decrease
Priorities 1-6.....	66.8%	74.4%	66.9%	66.6%	-0.3%
Priorities 7-8 1/.....	55.6%	74.3%	51.3%	80.6%	29.3%
Total Veterans.....	63.2%	74.3%	62.1%	69.2%	7.1%

1/Priority 7 and 8 veterans are higher-income veterans.

2/Non-veterans include spousal collateral consultations and instruction, CHAMPVA workload, reimbursable workload with affiliates, humanitarian care, and employees receiving preventive occupational immunizations.

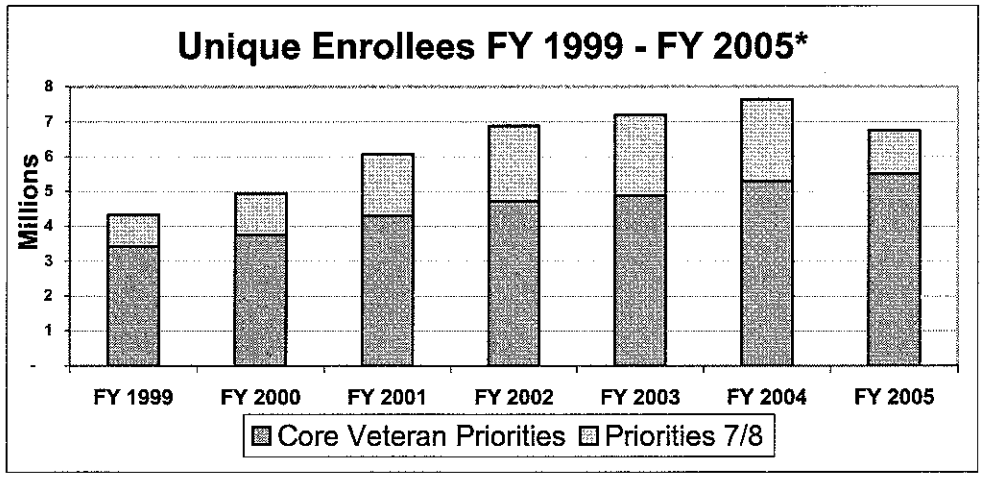
3/The 2004 unique patients and average enrollees budget estimate reflects legislative proposals to assess an annual enrollment fee and increase outpatient and pharmacy co-payments that have not yet been enacted into law.

4/VA has adopted a new definition for enrollees for 2003, 2004 current estimate, and 2005. In previous budgets, VA used average enrollees. In this budget, VA is using unique enrollees which are similar to unique patients. The count of unique enrollees represents the count of veterans enrolled for veteran's health care sometime during the course of the fiscal year, including those veterans who died during the fiscal year.

The 2005 budget request assumes that enrollment of new Priority 8 veterans will remain suspended. To further address the increasing health care workload and to ensure that VA continues to provide timely, high-quality health care to our core population, the budget request includes policy proposals focused primarily on veterans with comparatively higher incomes. These proposals would require lower priority veterans to assume a greater share of the cost of their health care. While veterans with comparatively higher incomes will pay enrollment fees and higher pharmacy co-payments, the budget eliminates co-payments for veterans receiving hospice care and for former Prisoners of War. In addition, the budget includes a provision that allows VA to pay for emergency room care received in non-VA facilities for enrolled veterans.

The history of VA medical service provides insight into whom we treat and why we must propose significant changes in current policies. The modern VA health care system began during World War I with establishment of hospitals to treat and rehabilitate veterans with service-connected disabilities. A second role was added in 1924 with the addition of hospital care for lower-income veterans. Higher-income veterans were added on a resource-available basis in 1986 (with the provision that these veterans pay a portion of their care), and comprised about 2 percent of veteran patients. In 2003, these veterans represented 26 percent of VA's patients and 32 percent of the enrollees. The following chart illustrates the 2001-2005 changes projected in veteran enrollment by these two major priority groupings.

Projected Enrollment
by Patient Priority



Reflects actual, unique enrollees for 1999–2003 and actuarial projections for 2004–2005 from the Fall 2003 VHA Health Care Demand Model.

Although the overall veteran population is projected to decline over the next 10 years, the demand for VA health care services continues to increase due to the

aging of veterans and the comprehensive health care services offered to veterans, including favorable pharmacy benefits; the national reputation of VA as a leader in the delivery of quality health care; long-term care services; and improved access to health care with the opening of additional community-based outpatient clinics. All of these factors have put a severe strain on VA's ability to continue to deliver quality health care, especially for veterans with service-connected conditions, those with lower incomes, and veterans with special needs. The enrollment decision directly addresses this situation and will continue to help ensure that more health care resources are available to meet the needs of its core population, especially those with disabilities that are the result of military service.

VA's appropriation request of $27.1 billion is comprised of five major resource initiatives. First, VA is proposing a comprehensive set of legislative and regulatory proposals that will continue to focus the VA health care system on care for service-connected disabled veterans as well as veterans with lower incomes and those who have special health care needs. To address the rapid growth in the number of health care users and to ensure that VA continues to provide timely, high-quality health care to our core population, these proposals focus primarily on veterans with comparatively higher incomes. The major components of this set of proposals are described below:

- Assess an annual enrollment fee of $250 for all Priority 7 and 8 veterans. Priority 7 veterans have incomes above $25,163 for a single veteran and below the HUD geographic means test level. Priority 8 veterans are those with incomes above $25,163 for a single veteran and above the HUD geographic means test. The HUD geographic means test is established at a local level such as county.
- Increase the veteran's share of pharmacy co-payments from $7 to $15 for a 30-day supply of prescriptions paid by veterans who have a greater ability to absorb these co-payments—Priority 7 and 8 veterans.
- Eliminate the pharmacy co-payment burden for Priority 2-5 veterans who have less ability to incur these costs by raising the income threshold from the pension level of $9,894 to the aid and attendance level of $16,509.

The legislative proposals required to implement these policy proposals are included in the administrative provisions of the appropriations request.

Second, VA is proposing six additional legislative or regulatory proposals that are designed to expand health care benefits for the Nation's veterans.

- The emergency care legislative proposal would give VA the authority to pay for insured veteran patients' out-of-pocket expenses for emergency services if their emergency care is obtained outside of the VA health care system. This

proposal ensures that all veterans, insured or non-insured, have consistent optimal health care, including care for any emergency condition.

- VA is requesting permanent authority and an annual spending level of up to $100 million for the Homeless Providers Grant and Per Diem Program. Currently, VA is authorized to conduct this program through September 30, 2005, with an annual spending level of $75 million. These additional funds will be used to assist faith-based and community-based organizations to further develop programs and services for homeless veterans.
- VA recommends a legislative proposal that will expand the 1998 average daily census (ADC) nursing home capacity requirement to include the following categories of extended care services: nursing homes, residential rehabilitation treatment programs, home care programs, and noninstitutional extended care services under the jurisdiction of the Secretary, plus the ADC for which the Department pays per diem to States for services in State homes.
- VA is proposing to exempt co-payment requirements for hospice care provided in any VA setting. Currently, veterans are charged a co-payment if hospice care cannot be provided in a VA nursing home bed either because of clinical complexity or lack of availability of nursing home beds. This proposal would eliminate the co-payment requirement for all hospice care provided in a VA setting so that veterans could equitably receive hospice care in any VA facility.
- VA is proposing to exempt former Prisoners of War (POWs) from co-payments for extended care services. Public Law 108-170, Veterans Health Care, Capital Asset, and Business Improvement Act of 2003, provided VA with the authority to exempt former POWs from the medication co-payment. Former POWs now have no co-payment for hospital and medical services.
- VA will, under its current regulatory authority, eliminate the current policy of placing veterans' accounts on hold pending payment by insurance companies. Veterans will receive a bill based on industry standard averages related to insurance coverage type. This revised procedure will streamline operations but still afford veterans the opportunity to receive a reduced co-payment as a result of having third-party health insurance.

Third, VA is requesting additional resources of $1.7 billion to care for nearly 5.2 million unique patients. The $1.7 billion is comprised of an increase of $507 million for appropriation funding, $666 million for collections, and $529 million from reimbursements and unobligated balances. VA will deliver community-based health care to these patients who require more health services as they age. VA forecasts an increase in workload and utilization from an actuarial model that projects workload and costing for the enrolled veteran population that will require basic benefits from the VA health care system. The changing health care demands reflect veterans' increasing reliance on pharmaceuticals; the aging of World War II and Korean conflict veterans, many of whom are in greater need of health care; and helping to ensure the outcome of high veteran satisfaction with VA health care

delivery. VA's budget request focuses on the Secretary's priority of providing timely and accessible health care that sets a national standard of excellence for the health care industry. To address this priority, the Department has set a 2005 performance goal of 93 percent for the share of primary care appointments that will be scheduled within 30 days of the desired date. For appointments with specialists, the comparable performance goal is 90 percent.

Fourth, VA is proposing additional management savings of $340 million in 2005 which will partially offset the overall cost of the projected growth in workload and utilization. These efficiencies will be achieved through improved standardization policies in the procurement of supplies, pharmaceuticals, and other capital purchases, as well as in other operational efficiencies such as consolidations.

Fifth, the budget provides capital investment resources of $582.9 million necessary to ensure VA's infrastructure is adequate to support the delivery of quality health care. Within this level of funding, VA is aggressively moving forward with the Capital Asset Realignment for Enhanced Services (CARES) program; $523.9 million of capital funding will be invested in 2005 to implement the recommendations of individual CARES studies. CARES was developed to identify the infrastructure VA will need to care for veterans in the 21st century. The CARES process will use existing resources to maximize the quality and amount of care VA provides to veterans and savings will be reinvested into direct patient care—doctors, nurses, and modern health care equipment. CARES is a systematic planning process to prepare VA's facilities and campuses to meet the future health care needs of veterans through a methodical, system-wide assessment of the current and future needs for space, and of the size, mission, and locations of facilities, compared to the number of projected enrollees and forecasts of their anticipated utilization of medical services. CARES is another step in the dynamic improvement process that characterizes the VA health care system. The CARES plan will ensure that VA is a health care system that balances the need for acute inpatient capacity to meet the needs of aging veteran enrollee population, the growing demands for outpatient services, and rehabilitation needs of special disability populations such as veterans with spinal cord injury, blindness, and traumatic brain injury.

VA's cooperative efforts with DoD continue to improve the health care delivery services of both agencies in support of the President's Management Agenda and the Congressional mandate in the 2003 National Defense Authorization Act, Public Law 107-314. The Departments have undertaken unprecedented efforts to improve cooperation and sharing in a variety of areas through the VA/DoD Joint Executive Council (JEC). The JEC, co-chaired by the VA Deputy Secretary and the DoD Under Secretary for Personnel and Readiness, provides a joint strategic road map for VA and DoD, and sets priorities for the VA/DoD Health Executive Council (HEC) and the VA/DoD Benefits Executive Council (BEC). The JEC implemented a joint strategic planning process to identify, monitor and facilitate the implementation of

joint initiatives. The HEC and BEC serve as forums for senior leader oversight. The Departments have identified numerous high-priority items for improved coordination such as capital asset planning, adopting the national item (coding) file in logistics, converting Distribution and Pricing Agreements (DAPAs) to VA Federal Supply Schedules, implementing computerized patient medical records, using joint separation physicals and compensation and pension examinations, and improving capital coordination.

The VA installations by category are provided below.

Medical Care
Number of VA Installations

	2003 Actual	2004 Estimate	2005 Estimate	Increase(+) Decrease (-)
Veterans Integrated Service Networks	21	21	21	+0
VA hospitals 1/	160	158	157	-+1
VA nursing homes 2/	134	133	133	+0
VA residential rehabilitation treatment programs 3/	42	42	42	+0
Hospital outpatient clinics	160	158	157	-+1
Community-Based Outpatient Clinics (CBOCs) 4/	676	698	711	+13
Independent outpatient clinics	4	4	4	+0
Mobile outpatient clinics	7	7	7	+0
Total outpatient clinics 5/	847	867	879	+12

1/ Decreases represent sites where acute inpatient care is being consolidated at other hospitals, leaving extended care (nursing home) as the primary service.
2/ The number of authorized Nursing Home Care Unit beds in VA increased from 17,081 to 17,159 (or 78 beds) from December 31, 2002 to December 31, 2003; however, some Nursing Home Care (NHC) bed sections were consolidated resulting in a total of 133 NHC units currently in use in VA.
3/ Formerly called domiciliaries.
4/ 2005 estimate may change as a result of the CARES report.
5/ Total outpatient clinics include hospital outpatient clinics, CBOCS, independent outpatient clinics, and mobile outpatient clinics.

Summary of Resource Increases and Decreases

Medical Care Business Line Summary of Resource Increases/Decreases (dollars in thousands)		
Item	FTE	Obligations
I. Program changes for 2005 over 2004 funding:		
1) Projected growth in workload and utilization:		
a.) Base health care demand	5,844	$1,120,337
b.) State home workload	0	21,883
c.) CHAMPVA and CHAMPVA for Life	0	60,692
d.) Real property and calendar day	0	-2,018
e.) Medical realignments (research support)	350	30,032
Subtotal	6,194	1,230,926
2) New or expanded initiatives:		
a.) Homeless Grant and Per Diem program	0	5,609
b.) Health care resources sharing project	0	9,000
c.) Physician and dentist pay	0	94,810
Subtotal	0	109,419
3) Proposed policies to focus care on core veterans:		
a.) Assess $250 annual enrollment fee for P7-8s	-849	-141,394
b.) Increase pharmacy co-payments from $7 to $15 for P7-8s	-495	-82,515
c.) Increase co-payments threshold to aid and attendance level	0	0
d.) Increase outpatient co-payments from $15 to $20 for P7-8s	0	-7,840
Subtotal	-1,344	-231,749
4) Legislative and regulatory proposals		
a.) Emergency care, insured	0	10,302
b.) Increase spending limit for Homeless Grant and Per Diem	0	8,957
c.) Count all nursing home care toward capacity requirement	-2,500	-270,489
d.) Co-payment exemption for hospice care	0	-192
e.) Long-term care co-payment exemption for former POWs	0	-49
f.) Eliminate first-party offset	0	0
Subtotal	-2,500	-251,471
5) Management savings	0	-340,000
Subtotal	-2,500	-591,471
6) Other medical care business line initiatives:		
a.) National program administration	-19	-1,360
b.) Construction to include CARES	0	180,004
c.) Grants for State extended care facilities	0	-52,704
Subtotal	-19	125,940
Total program changes	2,331	643,065
II. Payroll for existing employees	0	649,826
III. Inflation and rate changes	0	409,403
Total changes	2,331	$1,702,294

In 2005, the Medical Care Business Line requires an increase in total resources of $1.7 billion for medical services including National Program Administration (NPA), Grants for State Extended Care Facilities, and the Capital Asset Realignment for Enhanced Services (CARES) initiative. The $1.7 billion is comprised of an increase of $507 million for appropriation funding, $666 million for collections, and $529 million from reimbursements and unobligated balances. These increases are offset by a decrease of $1.2 billion in appropriation from a comprehensive set of legislative, regulatory, and management proposals that will continue our efforts to concentrate the VA health care system resources on our highest priority core veterans - those with service-connected conditions, those with lower incomes, and veterans with special health care needs. The programmatic changes, described below, highlight VA's major 2005 operational requirements.

- Increase of $649.8 million for payroll costs to support full-time equivalent (FTE) employment of 192,641 and an increase of $409.4 million for inflation and rate changes.

- Increase of $1.1 million and 5,844 FTE for the base health care demand initiative, which is for increased workload demand and patient utilization of medical services. VA will deliver community-based health care to 5.2 million users who require more health services as they age. This increase is derived from an actuarial model that projects workload and costing for the enrolled and user population that will demand benefits from the VA health care system. The utilization projections are based on private sector benchmarks adjusted to reflect the VA health care services package, veteran age, gender, morbidity, reliance on VA versus other health care providers, and degree of health care management. The changing health care demands reflect veterans' increasing reliance on pharmaceuticals; the aging of many World War II and Korean veterans who are in greater need of health care; and the outcome of high veteran satisfaction with VA health care delivery. This initiative also includes an increase of $259.5 million in collections that will result from third-party insurance collections and first-party other co-payments due to increased workload and utilization as well as through improvements in the collections process.

- Increase of $82.6 million for an increase of 1,010 in State home nursing census and additional CHAMPVA and CHAMPVA for Life claims.

- Increase of $94.8 million in additional funding for physician and dentist pay reform that VA assumes will be passed in 2004 which will greatly enhance theVA's ability to retain and recruit the highest quality clinicians.

- Increase of $5.6 million for the Homeless Grant and Per Diem program to provide additional grant-funded beds to support homeless veterans.

- Increase of $9 million for the health care resources sharing project to conduct eight demonstration projects designed to improve sharing and coordination of health care between VA and DoD.

- Decrease of $231.7 million and 1,344 FTE associated with implementing a comprehensive set of legislative or regulatory proposals designed to concentrate health services on VA's highest priority veterans. These proposals will assess an annual enrollment fee; change the veteran's share of outpatient and pharmacy co-payments; and increase the threshold for pharmacy co-payments. These proposals are estimated to increase collections by $376.7 million. The administrative provisions of the appropriations language contain the proposed legislation for these policy proposals.

- Decrease of $251.5 million for six additional legislative or regulatory proposals that are designed to expand health care benefits for the Nation's veterans described below.

  - Provide VA the authority to pay for insured veteran patients' out-of-pocket expenses for emergency services if their emergency care is obtained outside of the VA health care system ($10.3 million).

  - Provide permanent authority and authorize an annual spending level of up to $100 million for the Homeless Providers Grant and Per Diem Program. Currently, VA is authorized to conduct this program through September 30, 2005, with an annual spending level of $75 million. VA is proposing increasing this program from $69.4 to $75.0 million, an increase of $5.6 within its current spending level of $75 million. If the spending level is increased to $100 million, VA would increase the program from $75 million to $84 million, an additional $9 million increase.

  - Exempt co-payment requirements for hospice care provided in any VA setting. This proposal would eliminate the co-payment requirement for all hospice care provided in a VA setting so that veterans could equitably receive hospice care in any VA facility (-$192,000 in collections).

  - Expand the 1998 average daily census capacity requirement to include all categories of extended care services instead of using only VA nursing home ADC toward the capacity requirement (-$270.5 million and - 2,500 FTE).

  - VA is proposing to exempt former Prisoners of War (POWs) from co-payments for extended care services (-$49,000 in collections).

  - Eliminate the current policy of offsetting veterans' co-payments with collections from insurance companies (-$30.3 million in appropriation and +$30.3 in collections for a net change of $0 to the appropriation request).

- Decrease of $340 million for management savings in 2005 that will partially offset the overall cost of the increased workload and utilization. These savings will be achieved be achieved through improved standardization policies in the procurement of supplies, pharmaceuticals, and other capital purchases, as well as in other operational efficiencies.
- Increase of $125.9 million to fund the following other medical care business line initiatives:
  - NPA -- $1.4 million and 19 FTE decrease. In 2005, VA is requesting $87.1 million in total budgetary resources for NPA to provide corporate leadership and support to VA's comprehensive and integrated health care system. In 2005, the reduction reflects a proposed move of 16 research affiliated FTE currently under NPA into the Medical and Prosthetic Research Business Line.
  - VHA Construction -- $180 million increase. VA is requesting $582.9 million in direct appropriation for major and minor construction projects. Of the $180 million increase, $165.1 is in direct appropriation and $14.9 is from unobligated balances. VA is proposing funding of $361.8 million for CARES major construction projects and $162.1 million for CARES minor construction projects. Through the CARES strategic planning process, VA is assessing veterans' health care needs across the country, identifying planning initiatives to meet those needs in the future, and guiding the realignment and allocation of capital assets to implement the planning initiatives to support the delivery of quality health care.
  - Grants for State Extended Care Facilities -- $52.7 million decrease. This decrease is the result of an increase in 2003 obligations due to several factors in 2002 such as States not meeting mandatory grant requirements, deferring projects until 2003, or canceling project requests. Additionally, a one-time adjustment in 2002 grant processing procedures reflecting a congressionally mandated priority methodology produced a backup in the grant application processes which delayed funding until 2003. This new methodology has since been fully implemented and all grant applications are being processed as funds are available and State matching funds are provided.
  - DoD and VA Health Care Sharing Incentives Fund. This initiative provides $15 million in 2004 and 2005 to comply with Public Law 107-314, section 721, the FY 2003 National Defense Authorization Act. Congress requires VA and DoD to establish a joint incentive program to enable the Departments to carry out a program to identify and provide incentives to implement creative sharing initiatives at the facility, intra-regional, and nationwide levels. These funds are reflected as part of the Medical Care Business Line and are available until expended.

Workloads and Workload Indicators

The 2005 budget provides for the medical care and treatment of 746,990 inpatients with an average daily census of 54,896 and outpatient medical visits totaling 57.4 million. Workloads and indicators of the medical care and treatment programs are shown in the following tables. The treatment emphasis is placed on meeting patient health care needs and not on the location of care; therefore, this budget continues to streamline the presentation of activities that are more comparable to what is reported in today's health care industry.

Summary of Workloads for VA and Non-VA facilities

	2003 Actual	2004 Estimate	2005 Estimate	Increase(+) Decrease(-)
Acute hospital care:				
Average daily census	8,150	8,112	8,084	-28
Patients treated	476,413	491,324	506,315	+14,991
Length of stay in FY 1/	6.2	6.0	5.8	-0.2
Rehabilitative care:				
Average daily census	1,197	1,199	1,197	-2
Patients treated	15,471	15,566	15,720	+154
Length of stay in FY 1/	28.2	28.2	27.8	-0.4
Psychiatric care:				
Average daily census	3,147	2,803	2,506	-297
Patients treated	95,026	90,640	86,638	-4,002
Length of stay in FY 1/	12.1	11.3	10.6	-.70
Nursing home care:				
Average daily census	33,408	33,069	31,579	-1,490
Patients treated	92,516	87,954	79,820	-8,134
Length of stay in FY 1/	131.8	137.6	144.4	6.8
Subacute care:				
Average daily census	595	613	686	+73
Patients treated	17,183	16,496	15,505	-991
Length of stay in FY 1/	12.6	13.6	16.1	+3
Residential care:				
Average daily census	10,619	11,046	10,844	-202
Patients treated	45,207	44,165	42,992	-1,173
Length of stay in FY 1/	85.7	91.5	92.1	+0.6
Total inpatient facilities:				
Average daily census	**57,116**	**56,842**	**54,896**	**-1,946**
Patients treated	**741,816**	**746,145**	**746,990**	**+845**
Non-Institutional Long-Term Care				
Home and Community Based				
Average Daily Census	24,413	29,631	36,524	+6,893
Grand Total (Inpatient & H&CBC)				
Average Daily Census	**81,529**	**86,473**	**91,420**	**+4,947**

1/Similar to fiscal obligations, length of stay reflects only days of care generated in that fiscal year.

Summary of Workloads for VA and Non-VA facilities (continued)				
	2003 Actual	2004 Estimate	2005 Estimate	Increase (+) Decrease (-)
Outpatient visits (000):				
Staff	46,544	49,493	52,438	+2,945
Fee	3,216	3,622	4,043	+421
Readjustment counseling	996	998	1,000	+2
Total	50,756	54,113	57,481	+3,368
Staff and fee outpatient dental program:				
Staff examinations	458,361	490,000	490,000	+0
Staff treatments	134,073	140,000	140,000	+0
Fee cases	16,420	17,000	17,000	+0
CHAMPVA workloads: [1/]				
Inpatient census	291	334	357	+23
Outpatient claims (CHAMPVA and CHAMPVA for Life)	2,962,715	5,012,399	5,828,879	+816,480

1/ CHAMPVA care for certain dependents and survivors of veterans is provided in both inpatient and outpatient settings.

Employment Analysis *FTE by Activity*				
	2003 Actual	2004 Estimate	2005 Estimate	Increase(+) Decrease(-)
Acute hospital care	48,764	50,123	51,677	+1,554
Rehabilitative care	4,552	4,602	4,674	+72
Psychiatric care	12,216	12,220	12,258	+38
Nursing home care	22,192	22,193	19,382	-2811
Subacute care	2,977	2,375	1,897	-478
Residential care	4,908	4,920	4,935	+15
Outpatient care	78,782	84,023	87,543	+3,520
Miscellaneous benefits and services	8,384	8,803	9,243	+440
CHAMPVA	420	420	420	+0
National program administration	551	575	556	-19
Construction, major	6	6	6	+0
Construction, minor	50	50	50	+0
Total FTE	183,802	190,310	192,641	+2,331

Comparative Employment Ratios, VA Medical Centers

Staffing ratios (FTE/census) are expected to remain relatively stable in 2005. The number of staff per 1,000 outpatient visits will decline slightly, which reflects that VA's health care system is becoming more efficient in the delivery of ambulatory care services. This table does not include contract providers at VA medical centers.

Comparative Employment Ratios, VA Medical Centers

	2003 Actual	2004 Estimate	2005 Estimate	Increase(+) Decrease(-)
Staffing ratios (FTE/census):				
Acute hospital care	5.98	6.18	6.39	+0.21
Rehabilitative care	3.80	3.84	3.90	+0.06
Psychiatric care	3.88	4.36	4.89	+0.53
Nursing home care	0.66	0.67	0.61	-0.06
Subacute care	5.00	3.87	2.77	-1.10
Residential care	0.46	0.45	0.46	+0.01
FTE/1,000 patients treated:				
Acute hospital care	102	102	102	+0
Rehabilitative care	294	296	297	+1
Psychiatric care	129	135	141	+6
Nursing home care	240	252	243	-9
Subacute care	173	144	122	-22
Residential care	109	111	115	+4
FTE/1,000 outpatient visits	1.58	1.58	1.55	-0.03

Capital Investments

In the 2005 President's budget, VA is requesting $688.1 million in direct appropriation for capital investments, an increase of $168.7 million over the 2004 request. The request also includes 3.4 million for collections from parking fees. Capital investments consist of major and minor construction projects, grants for construction of State extended care facilities, and collections from parking fees.

Capital Investments 2005 Funding Reconciliation
(dollars in thousands)

	FY 2004 Estimate	FY 2005 Estimate	Increase (+) Decrease (-)
Capital Investments			
Construction, major (VHA portion)	$212,738	$400,800	+$188,062
Construction, minor (VHA portion)	205,082	182,100	-22,982
Grants for State extended care facilities	101,498	105,163	+3,665
Subtotal, capital investments appropriation	519,318	688,063	+168,745
Transfer from parking program collections	3,400	3,400	+0
Subtotal, capital investments budget authority	522,718	691,463	+168,745
Adjustments to capital investments obligations:			
Changes in unobligated balance			
Construction, major (VHA portion)	12,262	74,200	+61,938
Construction, minor (VHA portion)	50,918	3,904	-47,014
Grants for State extended care facilities	55,533	-836	-56,369
Parking program	8,253	100	-8,153
Subtotal, capital investments adjustments	126,966	77,368	-49,598
Total, capital investments obligations	**$649,684**	**$768,831**	**+$119,147**

The 2005 President's budget request includes $582.9 million in direct appropriation for major and minor construction, an increase of $165.1 million over the 2004 estimate.

Construction 2005 Appropriation Funding
(dollars in thousands)

	FY 2004 Estimate	FY 2005 Estimate	Increase (+) Decrease (-)
Major Construction Appropriation			
CARES	$180,000	$361,800	+$181,800
Advance planning fund	14,912	17,000	+2,088
Asbestos abatement	4,903	5,000	+97
Claims analyses	1,988	1,000	-988
Emergency response security	0	4,000	+4,000
Hazardous waste	994	2,000	+1,006
Judgment fund	9,941	10,000	+59
Subtotal, major construction	212,738	400,800	+188,062
Minor Construction Appropriation			
CARES	40,000	162,100	+122,100
Non-CARES	145,200	0	-145,200
Seismic	19,882	20,000	+118
Subtotal, minor construction	205,082	182,100	-22,982
Total, construction	**$417,820**	**$582,900**	**$165,080**

Major and Minor Construction (VHA portion)

Funding for construction provides for constructing, altering, extending, and improving any VA facility. This includes planning, architectural and engineering services, Capital Asset Realignment for Enhanced Services (CARES) activities, assessments, and site acquisition where the estimated cost of a project is $7,000,000 or over for major construction and less than $7,000,000 for minor construction. P.L. 108-170, raised the minor construction threshold from $4,000,000 to $7,000,000 million.

Grants for Construction of State Extended Care Facilities

Resources for grants for construction of State extended facilities provides for grants to assist States to acquire or construct State nursing home and domiciliary facilities and to remodel, modify, or alter existing hospital, nursing home, and domiciliary facilities in State homes, for furnishing care to veterans.

Parking Program (formerly Parking Revolving Fund)

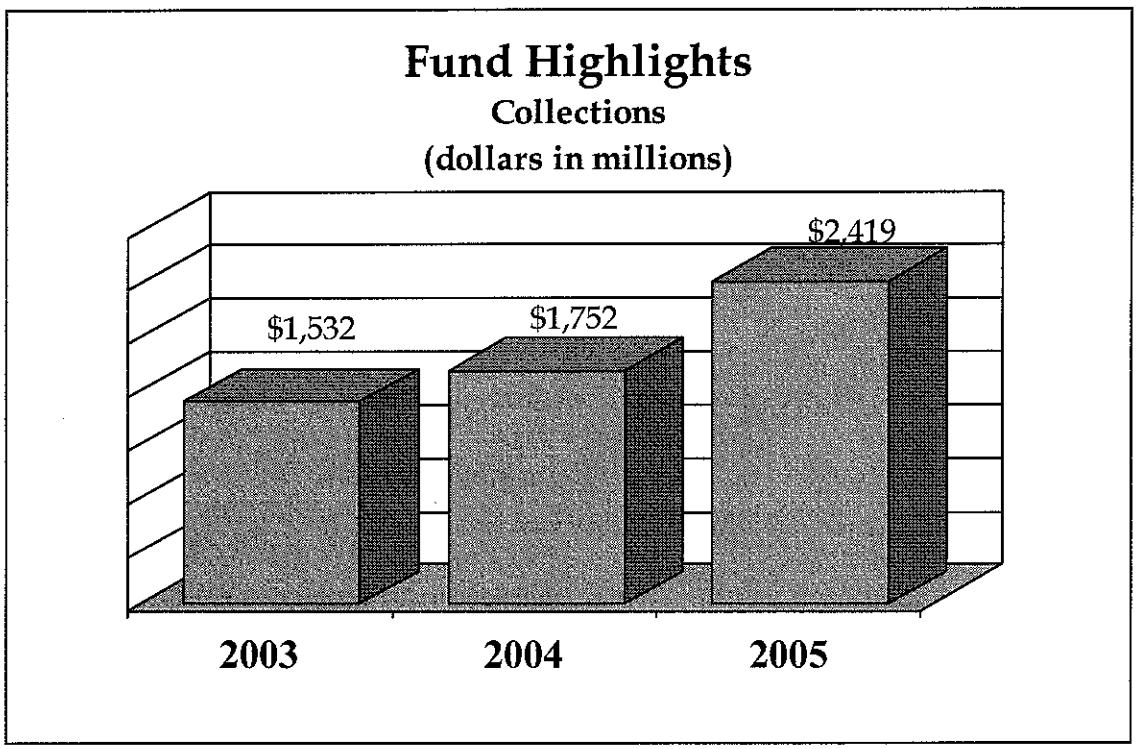
The Parking Program provides resources for leasing and construction of parking structures and surface parking to accommodate the vehicles of employees of medical facilities, vehicles used to transport veterans and eligible persons to or from these facilities for examination or treatment, and the vehicles of visitors and other individuals having business at these facilities. VA collects fees for the use of these parking facilities at VA facilities.

Sale of Assets (formerly the Nursing Home Revolving Fund)

This program provides for construction, alteration, and acquisition (including site acquisition) of medical care facilities through collections that may be realized from the transfer of any interest in real property that is owned by the United States and administered by the Department of Veterans Affairs.

Medical Care Collections Fund

VA estimates collections of more than $2.4 billion, representing over 8 percent of the available resources in 2005 and an increase of $666 million, a 38 percent increase over the 2004 estimate. Under the new account structure, medical collections will consist of the Medical Care Collections Fund (MCCF), pharmacy co-payments, enhanced use revenue, long-term care co-payments (Veterans Extended Care Revolving Fund), Compensated Work Therapy Program (Special Therapeutics Rehabilitation and Activities Fund), Parking Program (Parking Revolving Fund), and Compensation and Pension Living Expenses Program (Medical Facilities Revolving Fund). The objective of consolidating all collections into the MCCF is to improve planning, simplify systems, enhance the recovery of funds, and focus on accountability for medical collections. Legislation is being proposed to combine these accounts into the MCCF.



Medical Care Collections Summary of Fund Activity (dollars in thousands)				
	2003 1/ Actual	2004 Estimate	2005 Estimate	Increase(+) Decrease(-)
Pharmacy co-payments	$576,554	$656,700	920,210	+$263,510
Third-party insurance collections	804,141	916,500	1,037,000	+120,500
First-party other co-payments	104,994	128,800	406,000	+277,200
Enhanced use revenue	234	500	500	+0
Long-term care co-payments	3,461	6,000	9,000	+3,000
Compensated work therapy	38,834	40,116	42,189	+2,073
Compensation and pension living expenses	376	388	401	+13
Parking fees	3,296	3,400	3,400	+0
Total collections	$1,531,890	$1,752,404	$2,418,700	+$666,296

1/ Pharmacy co-payments, third-party insurance collections, first-party other co-payments, and enhanced use revenue collections. These numbers reflect collections of $1,485,923,721 received by VA in 2003. Due to the difference in the timing from when the funds are received and transferred into the medical care account, previous charts reflect $1,474,715,412 transferred to the medical care account in 2003. The remainder of the funds collected in 2003 will be transferred in 2004.

Long-term care co-payments, compensated work therapy, compensation and pension living expenses, and parking fees. In 2003 and 2004, collections from these accounts are reflected for comparable purposes because these collections will be consolidated into the MCCF in 2004.

Medical Care Collections Fund

Public Law 105-33, the Balanced Budget Act of 1997, established the Department of Veteran Affairs Medical Care Collections Fund (MCCF) and requires that amounts collected or recovered after June 30, 1997, be deposited in this fund. VA has the authority to collect inpatient, outpatient, medication, and nursing home co-payments; authority for certain income verification; authority to recover third-party insurance payments from veterans for non-service connected conditions; and authority to collect revenue from enhanced use leases. Public Law 108-7, the Consolidated Appropriations Resolution, 2003, granted permanent authority to recover pharmacy co-payments for outpatient medication. VA's authority to do income verification with the Social Security Administration and Internal Revenue Service was extended through September 30, 2008, by section 402(d) of Public Law 106-419, the Veterans Benefits and Health Care Improvement Act of 2000. Public Law 107-135, Department of Veterans Affairs Health Care Programs Enhancement Act of 2001, extended the authority to recover third party insurance payments from service-connected veterans for nonservice-connected conditions through October 1, 2007.

Improving Collection in the Future

- With the establishment of the VHA Chief Business Office (CBO) an expanded revenue improvement strategy has been formulated that combines the 2001 Revenue Improvement Plan with a series of additional tactical and strategic objectives targeting a combination of immediate, mid-term and long-term improvements to the broad range of business processes encompassing VA revenue activities. Following guidance articulated in the President's Management Agenda, the Chief Business Office has pursued its current revenue improvement strategy by modeling industry best performance. To that outcome the strategies now being pursued include establishment of industry based performance and operational metrics, development of technology enhancements and integration of industry proven business approaches including the establishment of centralized revenue operation centers.

- VA implemented Reasonable Charges in September 1999 for billing third-party payers. These charges are comparable to charges used in the private sector for the same services in the same geographic area. Inpatient facility charges are based on Diagnosis Related Groups (DRG) based rates and outpatient facility charges and professional charges are based on Current Procedural Terminology (CPT) codes. These charges have helped to increase overall recoveries and more accurately captures care provided to veterans. VA continues to enhance and improve reasonable charges to ensure accuracy and completeness.

- Accurate insurance information is critical for VHA to maintain and exceed its current levels of recoveries. The past few years have seen a dramatic decline in inpatient days of care provided and a large increase in the number of outpatient clinic visits. This shift translates into lower revenues for inpatient services and higher revenue for outpatient care. VHA has mandated that all facilities establish patient pre-registration, to include the use of software that assists in gathering and updating the patient insurance information files.

- VA is working with the Center for Medicare/Medicaid Services (CMS) contractors for the purpose of providing VA with a Medicare-equivalent remittance advice (MRA) for veterans who are using VA services and are covered by Medicare. These MRAs will reflect the deductible and coinsurance amounts that Medicare supplemental insurers will use to reimburse VA for health care services VA provided to veterans for their non-service connected treatment. Improved revenue collections by VA are the expected outcomes of providing remittance notices along with VA claims to health plans that provide coverage secondary to Medicare.

- Leveraging the health care industry's migration to national standard electronic data exchanges under the Health Insurance Portability and Accountability Act (HIPAA), the following initiatives are underway to add efficiencies to the billing and collections processes.

  - The electronic Insurance Identification and Verification (e-IIV) project will provide VA medical centers (VAMCs) with an automated mechanism to obtain veterans' insurance information from health plans that participate in the electronic data exchange.

  - The electronic Payments or Third Party Lockbox (e-Payments) initiative will enable the receipt and posting of third party electronic payments and remittance advices from health plans against third party health care claims.

  - Enhancements to existing electronic Claims (e-Claims) software are underway to incorporate new requirements of the HIPAA Electronic Transactions and Code Sets Final Rule.

- In response to a Congressional requirement to acquire and implement a commercial patient financial services system, VA is implementing the Patient Financial Services System (PFSS) project in VISN 10. The project envisions a comprehensive implementation of business process and information technology improvements. This "end-to-end" solution will evaluate and recommend enhancements to business processes and information systems from enrollment and registration through accounts receivable management functions.

- Under VA's regulatory authority, it will increase the veteran's share of co-payments for outpatient primary care from $15 to $20 for veterans who have a greater ability to absorb these co-payments—Priority 7 and 8 veterans.

Pharmacy Co-Payments (formerly collected in the Health Services Improvement Fund (HSIF))

Public Law 108-7, the Consolidated Appropriations Resolution, 2003, granted permanent authority to recover co-payments for outpatient medication and transferred the collections from the HSIF to the MCCF.

The Millennium Health Care and Benefits Act, P.L. 106-117, provided the authority to collect co-payments as a result of any increase in pharmacy co-payments. The funds are available without fiscal year limitation. P.L. 106-117 authorized the Secretary to increase the $2 prescription drug co-payment, established a maximum annual and monthly payment applicable to veterans with multiple outpatient prescriptions, and revised co-payments in outpatient care for higher-income,

nonservice-connected veterans. Legislation is being proposed to increase these rates from the current rate of $7 to $15 for Priority 7 and 8 veterans.

Enhanced Use Revenue (formerly collected in the Health Services Improvement Fund (HSIF))

Veterans Affairs is engaged in looking for alternative uses for excess existing space. This asset management approach will reduce VA operating expenses, generate revenue to support veterans' health care cost, and provide needed services to the local community. The Millennium Health Care and Benefits Act, P.L. 106-117, provided the authority to collect revenues as a result of VA's amended enhanced use-lease authority.

Long-Term Care Co-Payments (formerly the Veterans Extended Care Revolving Fund)

The authority to collect long-term care co-payments was established by the Veterans Millennium Health Care and Benefits Act, P.L. 106-117. This fund receives per diems and co-payments from certain patients receiving extended care services as authorized in title 38, U.S.C., section 1710(B) and are used to provide extended care services. Extended care services are defined as geriatric evaluation, nursing home care, domiciliary services, adult day health care, and other noninstitutional alternatives to nursing home care.

Compensated Work Therapy (CWT) Program (formerly the Special Therapeutic and Rehabilitation Activities Fund)

This program, established by the Veterans Omnibus Health Care Act of 1976, Public Law 94-581, provides a mechanism for furnishing rehabilitative services to certain veteran beneficiaries receiving medical care and treatment from VA. This is a self-sustaining program that does not require an appropriation. Funds collected in this program are derived from actual work performed by patients and members in VA health care facilities under contracts developed with private industry, non-profit organizations, and state and Federal entities. The collections from this program pay for: patient salaries; the purchase of equipment, supplies, and contractual services necessary to complete the subcontracted work; and the travel of CWT staff for demonstrative and educational purposes.

Compensation and Pension Living Expenses Program (formerly the Medical Facilities Revolving Fund)

The Compensation and Pension Living Expenses Program was established by the Veterans Benefits Act of 1992, P.L. 102-568, and consists of funds transferred from

the Pension appropriation (formerly the Compensation and Pensions appropriation). Public Law 105-368, Veterans Programs Enhancement Act of 1998, has granted permanent authority for the transfer of pension funds in excess of $90 per month from the pension account, in accordance with the provisions of title 38 U.S.C., Section 5503(a)(1)(B). These funds are used to assist in the operation of VA medical facilities.

Under the provisions of 38 U.S.C. Chapter 55, veterans who do not have either a spouse or child, may have their monthly pension payments reduced to $90. This reduction begins after the end of the third full calendar month a veteran is admitted for nursing home care. The difference between the veteran's regular monthly pension payment and the $90 is collected in this program for future use by the individual VA facility. VA uses these no-year funds for non-payroll items, excluding employee travel at the VA facility providing the patient's care.

Parking Program (formerly the Parking Revolving Fund)

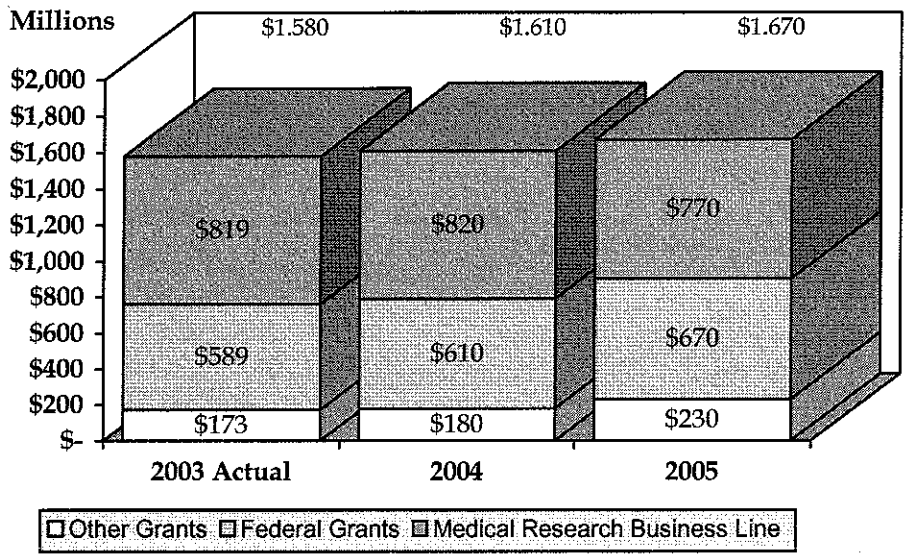
The Parking Program is for leasing and construction of parking structures and surface parking to accommodate the vehicles of employees of medical facilities, vehicles used to transport veterans and eligible persons to or from these facilities for examination or treatment, and the vehicles of visitors and other individuals having business at these facilities. VA collects fees for the use of these parking facilities at VA facilities.

Medical and Prosthetic Research Business Line

The Medical and Prosthetic Research Business Line appropriation is comprised of both the Medical and Prosthetic Research and the Medical Care Research Support accounts. The Medical and Prosthetic Research account is an intramural program, whose mission is to advance medical knowledge and create innovations to advance the health and care of veterans and the nation. It supports research that facilitates and improves the primary function of VHA, which is to provide high quality and cost-effective medical care to eligible veterans and contribute to the Nation's knowledge on disease and disability. This appropriation provides funds for the conduct of the VA's Medical, Rehabilitation, Health Services and Cooperative Studies research programs. The Medical and Prosthetic Research appropriation request of $769.5 million supports 46 percent of the research effort, with the balance coming from other VA appropriations as well as private and public funding contributions. It is expected that non-VA funding will increase in 2005.

Medical Care Research Support, previously paid from the Medical Care appropriation, contributes funding towards the indirect cost of the VA Research and Development program and is estimated to be $385 million in 2005. This includes: facility costs of heat, light, telephone and other utilities associated with laboratory space; administrative cost of human resource support, fiscal service, and supply service attributable to research; research's portion of a medical center's hazardous waste disposal and nuclear medicine licenses; and, most importantly, the time clinicians devote to their research activities. Over 76 percent of VA investigators are clinicians, who provide direct patient care to veterans in addition to performing research. This activity will now be reflected in the Medical Research Business Line.

Summary of Budgetary Resources



Overall, VA is projectiong a $60 million increase in total research resources of $1.67 billion. For direct appropriation, VA is requesting $769.5 million, which is a 6.1 percent decrease over the 2004 level and $110 million increase in grant funding. The following table summarizes the budgetary resources for the Medical and Prosthetic Research Business Line activities. In addition to receiving direct support for VA initiated research from appropriated funds, VA clinician/investigators compete for and obtain funding from other Federal and non-Federal sources. Their success is a direct reflection of the high caliber of VA's corps of researchers who are able to work in an environment conducive to research. In addition to outside funding, the Medical and Prosthetic Research program receives support from the Medical Care appropriation, which funds laboratory facilities and ancillary support services and pays a portion of clinician/investigators' salaries.

Summary of Resources
(dollars in thousands)

	2003 Actual	2004 Estimate	2005 Estimate
Medical Research Business Line	$817,610	$819,795	$769,540
Federal Grants	$589,000	$610,000	$670,000
Other Grants (voluntary agencies)	$173,000	$180,000	$230,000
Total	$1,579,610	$1,609,795	$1,669,540

Veteran health issues are addressed comprehensively in the four program divisions as follows:

Bio-medical Laboratory Science Research and Development Service– Bio-medical Laboratory Science Research will encompass all basic science and pre-clinical research, including but not limited to anatomy, biochemistry, biophysics, microbiology, virology, neuroscience, engineering, materials science, pharmacology, physiology, genetics, molecular biology, and animal models of human diseases.

Clinical Science Research and Development Service – Clinical Science Research will encompass interventional and observational studies in humans, including but not limited to pharmacological and surgical studies. Single subject, pilot studies, feasibility trials and cooperative studies will all be funded and managed by the Clinical Research Service. Phase 1 trials will not be the focus, but will be considered on a case-by-case basis.

Health Services Research and Development Service – Health Services Research will manage and fund research related to population studies, health economics, quality of care, and epidemiology. Translational studies for applying best practices will also be an important continuing role for HSR&D.

Rehabilitation Research and Development Service – Rehabilitation Research and Development will fund and manage all research related to chronic disabling conditions in veterans, including but not limited to nervous system diseases and injury, limb loss, rehabilitation engineering, and chronic medical conditions. Studies of rehabilitation treatment efficacy, rehabilitation outcomes and ascertaining the impact of rehabilitation strategies on Cure and Care will be a fundamental component of the RR&D portfolio.

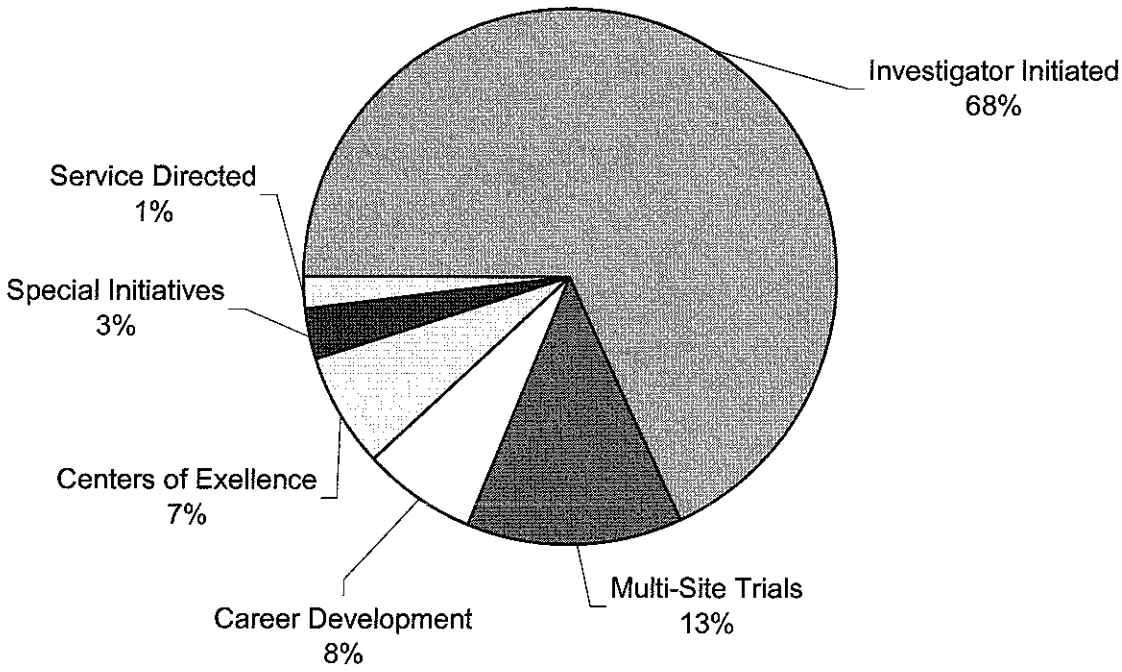
In 2005, the research program will continue its strong support of projects originated in prior years. In addition, it will continue its strong commitment and increased emphasis on Designated Research Areas (DRA's) highly relevant to the health care needs of veterans.

Obligations, Budget Authority, and Employment (dollars in thousands)				
	2003 Actual	2004 Estimate	2005 Estimate	Increase Decrease
Medical Research Business Line				
Obligations (gross)	$847,512	$890,511	$819,540	-$70,971
Offsetting collections	-$56,512	-44,000	-50,000	+6,000
Average employment (FTE):				
Direct	6,149	6,239	5,740	-499
Reimbursable	426	260	260	0
Total	6,575	6,499	6,000	-499
Appropriation	$817,610	$819,795	$769,540	-$52,662
Outlays:				
Obligations (net)	$793,817	$846,511	$769,540	-$76,971
Obligated balance, start of year	118,981	122,537	156,900	34,363
Obligated balance, end of year	-122,537	-156,900	-159,253	647
Adjustments in accounts	-6,972	0	0	0
Total Outlays (net)	$783,289	$812,148	$770,187	-$41,961

For the Medical and Prosthetic Research Business Line, a total of $769.5 million and 6,000 FTE will provide 46 percent of the $1.6 billion total research funding and support over 2,885 high-priority research projects focused in Designated Research Areas (DRAs). The number of projects is expected to decrease by 119 from the 2004 level. The other funding comes from other federal and private medical research organizations such as the Department of Defense and National Institute of Health. This level of funding will allow the research program to maintain research centers in the areas of Gulf War illnesses, diabetes, heart disease, chronic viral diseases (e.g., HIV/AIDS), Parkinson's disease, spinal cord injury, prostate cancer, depression, environmental hazards, and women's issues, as well as rehabilitation and Health Services Research and Development (HSR&D) field programs. VA will continue to seek to increase non-appropriated research funding from the private and public sectors. The 2005 request will maintain the research effort directed towards improving veterans health and care.

The Functional Research Portfolio pie chart that follows shows the distribution of VA's research among five different types of investigative approaches. The investigator-initiated research and Multi-site Trials portion of the portfolio make up 81 percent of the entire program. This is indicative of the openness of the system to new ideas.

Functional Research Portfolio



Projects by Designated Research Areas				
	2003 Actual	2004 Estimate	2005 Estimate	Increase Decrease
Designated Research Areas:				
Aging	674	657	637	-20
Cancer	208	209	188	-21
Infectious Diseases	110	110	99	-11
Kidney Diseases	87	88	79	-9
Diabetes and Major Complications	89	90	80	-10
Lung Disorder	109	109	98	-11
Heart Diseases	212	213	191	-22
Other Chronic Diseases	374	359	359	0
Mental Illness	194	187	186	-1
Substance Abuse	180	175	172	-3
Sensory Loss	88	85	84	-1
Acute and Traumatic Injury	371	364	374	-17
Health Systems	227	218	218	0
Special Populations	108	104	104	0
Military Occupations & Environmental Exposures	196	191	185	-6
Emerging Pathogens/Bio-Terrorism	27	27	24	-3
Digestive Diseases	128	128	115	-13

The Designated Research Areas (DRA) listed above, represent areas of particular importance to our veteran population. Because of the multiplicative nature of

research, many individual research projects have a bearing on more than one DRA. For example, heart disease relates both to chronic disease and aging. This research helps us perform our mission "to discover knowledge and create innovations that advance the health and care of veterans and the nation."

Canteen Service Revolving Fund

Current revenues finance this revolving fund and provide for the maintenance and operation of the Veterans Canteen Service at all VA hospitals and domiciliaries. The canteens provide reasonably priced merchandise and services to comfort veterans in hospitals, nursing homes, and domiciliaries.

Profit and Loss Statement
(dollars in thousands)

	2003 Actual	2004 Estimate	2005 Estimate	Increase Decrease
Average employment	2,837	2,850	2,850	0
Revenue	$229,109	$239,471	$244,553	+$5,082
Expense (-)	-$255,065	-$238,531	-$243634	-$5103
Net operating income	$4,044	$940	$919	-$21
Non-operating income (+) or loss (-)	-$408	$130	$235	+$105
Net income	$3,636	$1,070	$1,154	+$84
Outlays	-$4,814	$500	$700	+$200

Medical Center Research Organizations

Public Law 100-322 added a subchapter to Chapter 73 of title 38 entitled "Medical Center Research Organizations." This public law authorized the creation of Department of Veterans Affairs' medical center nonprofit organizations to provide a flexible funding mechanism for the conduct of research. These organizations derive funds to operate various research activities from Federal and non-Federal sources. This fund is self-sustaining, and requires no appropriation to support these activities.

Fund Highlights
(dollars in thousands)

	2003 Actual	2004 Estimate	2005 Estimate	Increase Decrease
Contributions	$185,563	$189,274	$190,726	+$1,452
Obligations (expenses)	$174,035	$177,516	$181,244	+$3,728

General Post Fund, National Homes

This trust fund is used to promote the comfort and welfare of veterans in hospitals and homes where no general appropriation is available. The fund consists of gifts, bequests and proceeds from the sale of property left in the care of VA facilities by former beneficiaries who die leaving no heirs or without having otherwise disposed of their estate. Donations from pharmaceutical companies, nonprofit corporations and individuals to support VA medical research can also be deposited into this fund.

No appropriation funding is being requested for the transitional housing loan program for 2005 because no loan activity on this program has occurred since its inception in September 1994. Although there were numerous inquiries about the program and requests for application materials, to date only one complete application has been received (which was disapproved due to the financial status of the organization and planned use of loan proceeds).

Obligations and Budget Authority
(dollars in thousands)

	2003 Actual	2004 Estimate	2005 Estimate	Increase Decrease
Program:				
Obligations	$29,848	$31,089	$31,742	$653
Budget authority (permanent, indefinite)	$30,576	$38,058	$38,857	+$799